114.3 CMR: Division of Health Care Finance and Policy

114.3 CMR 43.00: HOSPICE SERVICES

Section

43.01: General Provisions

(1) Scope, Purpose and Effective Date. 114.3 CMR 43.00 shall govern the determination of rates of payment to be used by all governmental units paying eligible providers for hospice services provided to publicly-aided individuals. 114.3 CMR 43.00 shall be effective October 1, 2004. The rates set forth in 114.3 CMR 43.00 also apply to individuals covered by M.G.L. c. 152 (the Worker's Compensation Act).

(2) Disclaimer of Authorization of Services. 114.3 CMR 43.00 is not authorization for or approval of the procedures for which rates are determined pursuant to 114.3 CMR 43.00. Governmental units that purchase care are responsible for the definition, authorization, and approval of care and services extended to publicly-aided clients.

(3) Authority. 114.3 CMR 43.00 is adopted pursuant to M.G.L. c118G.

43.02: Definitions

As used in 114.3 CMR 43.00, terms shall have the meanings ascribed in 114.3 CMR 43.02.

Continuous Home Care. Continuous home care may be provided only during a period of crisis in which a patient requires continuous care, predominantly nursing care, at home to achieve palliation or management of acute medical symptoms. Homemaker and/or home health aide services may also be covered on a continuous basis. The continuous home care rate will be paid on an hourly rate basis for each day, or portion thereof, that a recipient qualifies for and receives such care. A minimum of eight hours must be provided in a 24-hour period to qualify for the continuous home care rate.

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Eligible Provider. Any Medicare-certified organization licensed under state law as a provider of hospice services.

General Inpatient Care. General inpatient care is care provided in a participating hospice inpatient unit or hospital, or skilled nursing facility, that additionally meets

the special hospice standards set by CMS regarding staffing and patient areas. Services provided in an inpatient setting must conform to the written plan of care. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management which cannot be managed in other settings. Payment at the inpatient rate will be made when general inpatient care is provided.

Governmental Unit. The Commonwealth, any department, agency, board or, commission of the Commonwealth and any political subdivision of the Commonwealth

Inpatient Care Limitation. For Medicaid, the total payment to the hospice for inpatient care (general or respite) is subject to a limitation that total inpatient care days for all Medicaid patients for a 12-month period may not exceed 20% of total days for which these patients have elected hospice care; however, days to be used by individuals with Acquired Immune Deficiency Syndrome (AIDS) are exempt from the number of inpatient care days counted toward the 20% limitation.

Hospice. Public agency or private organization or a subdivision of either that is providing care to terminally ill individuals and meets the Medicare conditions of participation specified in 42 CFR 418.50-418.98 for hospices. If it is a freestanding hospice that provides inpatient care directly, it must meet the conditions of 42 CFR 418.100. Core services (provided directly by hospice employees) include:

Nursing Services.
Physician Services.
Medical Social Services.
Counseling Services.
Supplemental services (may be on a contract basis) include:
Short-term Inpatient Care.
Medical Appliances and Supplies, Including Drugs and Biologicals.
Home Health Aide and Homemaker Services.
Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services.

Inpatient Respite Care. Respite care is short-term inpatient care provided to the individual in an approved inpatient facility only when necessary to relieve the family members or other persons caring for that individual. Respite care may be provided only on an occasional basis and shall be limited to no more than five consecutive days. Reimbursement for the sixth and any subsequent days is made at the routine home care rate.

Publicly-Aided Individual. A person for whose medical and other services a governmental unit is in whole or part liable under a statutory program

Room and Board. An additional per diem amount is paid to the hospice on routine or continuous care days for an individual residing in an intermediate care or skilled

nursing facility which must be equal to at least 95% of what the facility would have been paid by the state for a non-hospice Medicaid beneficiary. Room and board includes performance of personal care services, including assistance in activities of daily living, in socializing activities, administration of medication, maintaining the cleanliness of a resident's room, and supervision and assistance in the use of durable medical equipment and prescribed therapies.

Routine Home Care. The hospice will be paid the routine home care rate for each day the patient is at home, under the care of the hospice, and not receiving continuous home care. This rate is paid without regard to the volume or intensity of routine home care services provided on any day.

Terminally Ill. Recipient has a medical prognosis that his/her life expectancy is 6 months or less.

43.03: Filing and Reporting Requirements

(1) Required Reports. Each eligible provider must file the following information no later than 90 days after the close of the fiscal period.

(a) A Medicare hospice cost report and supplemental data.

(b) Financial statements certified by a certified public accountant. In the absence of certified statements, the agency may submit uncertified statements or a balance sheet and operating statement prepared by the agency.

(2) Examination of Records. Each agency shall make available all records relating to its operation for audit, if requested by the Division and according to the requirements mentioned in 114.3 CMR 43.03 under Field Audit.

(3) Charge Filing. Each agency shall file a complete schedule of charges to the public with its annual cost report and shall notify the Division of any change in charge to the public during the year.

(4) Additional Information Requested By the Division . Each agency shall file such additional information as the Division may from time to time require, no later than 30 days after a written request.

(5) Accurate Data. All reports, schedules, additional information, books and records which are filed or made available to the Division shall be certified under pains and penalties of perjury as true, correct, and accurate by the Executive Director or Financial Officer of the Agency.

(6) Non-Compliance. Failure by an eligible provider to submit accurate and timely information as requested in 114.3 CMR 43.00 may result in delay, reduction or elimination of the rate or rates in question.

(7) Contracts. Each eligible provider who contracts for short-term inpatient care or other direct care service including but not limited to physical therapy, occupational therapy, speech/language therapy, homemaker/home health aide services, medical appliances and supplies, drugs and biologicals shall file with the Division a copy of all contracts which it has entered into, or enters into, after the effective date of 114.3 CMR 43.00.

(8) Field Audit. The Division shall determine if a field audit is necessary to substantiate information contained in the cost report. The Division shall make reasonable attempts to schedule an audit at the mutual convenience of both parties.

43.04 General Rate Provisions

(1) Effect of 114.3 CMR 43.00. The rates of payment under 114.3 CMR 43.00 shall constitute full compensation for hospice services provided to publicly-aided individuals, including necessary administration and professional supervision. These established rates of payment for authorized services with the exception of payment for room and board shall be set in accordance with CMS regulation 42 CFR 418.302.

(2) Rate Determination. Each payment rate is determined by CMS to reflect the cost incurred by a hospice in efficiently providing the core and supplemental services associated with that type of hospice care to Medicaid beneficiaries. The allowable Medicaid Hospice rates shall be determined in accordance with the provisions of the CMS regulation 42 CFR 418.302. The Medicaid rates shall be determined by adding the unweighted amount to the wage component as adjusted to reflect local differences in wages in accordance with CMS regulation 42 CFR 418.306.

(3) Rates. Allowable rates for hospice services are outlined below:

(a) If CMS amends the amounts listed in 42 CFR 418.306, the Medicaid rates will change accordingly. Said changes will be listed in a Division of Health Care Finance and Policy "Information Bulletin".

(b) For those Hospice clients residing in nursing homes, the per diem rate shall equal 95% of the rate that would have been paid by the state to a particular nursing home facility for a nonhospice Medicaid beneficiary.

Essex, Norfolk, Middlesex, Plymouth, Bristol, Worcester and Suffolk Counties

Routine Home Care	$138.69/per diem
Continuous Home Care	33.70/hour
Inpatient Respite	147.00/per diem
General Inpatient Care	611.10/per diem

Berkshire County

Routine Home Care	$130.13 per diem
Continuous Home Care	31.62/hour
Inpatient Respite	139.66/per diem
General Inpatient Care	575.67/per diem

Hampden and Hampshire Counties

Routine Home Care	$132.52/per diem
Continuous Home Care	32.20/hour
Inpatient Respite	141.71/per diem
General Inpatient Care	585.57/per diem

Franklin, Dukes and Nantucket Counties

Routine Home Care	$131.53/per diem
Continuous Home Care	31.96/hour
Inpatient Respite	140.87/per diem
General Inpatient Care	581.48/per diem

Barnstable County.

Routine Home Care	$154.11/ per diem
Continuous Home Care	37.44/ hour
Inpatient Respite	160.21/ per diem
General Inpatient	674.90/ per diem

43.05 Severability of Provisions

The provisions of 114.3 CMR 43.00 are hereby declared to be severable. If any such provisions or the application of such provisions to any eligible provider or circumstances shall be held invalid or unconstitutional, such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions of 114.3 CMR 43.00 or the application of such provisions to eligible providers or circumstances other than those held invalid.

REGULATORY AUTHORITY

114.3 CMR 43.00: M.G.L. c.118G